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a practice dedicated to personalized child care from cradle to college

MEDICAL RELEASE AUTHORIZATION FORM

TO: ____
Previous Physician or Hospital

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Address

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City/State/Zip

I hereby authorize and request you to release to:

AMHERST PEDIATRIC ASSOCIATES
25 HOPKINS ROAD
WILLIAMSVILLE, NEW YORK 14221

The complete medical records in your possession concerning my illness and/or treatment during the period from ________________ to ________________.

Patient's Name: ______________________________ DOB: ______________

Address: ____

____

Phone: ____

______________________________ ______________
Signature Date